

EXHIBIT 3



EMORY
UNIVERSITY
SCHOOL OF
MEDICINE

Department of Neurosurgery

Daniel L. Barrow, MD
Pamela R. Rollins Professor and Chairman

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I have been asked by Staci Miller to review the circumstances surrounding the injury and surgery of Jerry Blasingame, and in particular, to evaluate the testimony of Thomas Burns for accuracy.

On 7/10/2018, Mr. Blasingame was involved in an incident with the Atlanta Police Department and was reportedly running from police when he was tasered and fell down a 30-foot embankment. As a result of the fall, he sustained multiple traumatic injuries. Upon arrival of medical personnel, he was unconscious with a Glasgow Coma Score of 3, which is the lowest possible score. A Grady EMS report indicates Mr. Blasingame had a large hematoma around his right eye, a large amount of blood running from his nose and a large pool of blood next to his head. Mr. Blasingame had a pulse of 78 with agonal breathing and was unresponsive with pinpoint pupils. He was treated, monitored, and transported to Grady Memorial Hospital where he was resuscitated and underwent multiple imaging studies to determine the extent of his injuries.

A CT of his head demonstrated evidence of subarachnoid hemorrhage, pneumocephalus along the left frontal and temporal lobes and right temporal lobe. There was evidence of a chronic right caudate infarction. CT of the face demonstrated comminuted facial and calvarial fractures including a zygomatic fracture, a left hemi-LeFort III fracture, a nasoethmoid fracture including a comminuted ethmoidal roof fracture, left fronto-temporal skull fracture, right anterior maxillary fracture, left orbital rim fracture extending into the region of the cavernous sinus, and a right occipital condyle fracture.

Imaging of the cervical spine demonstrated an abnormal signal in the spinal cord from C3-C5 with associated cervical stenosis. He was diagnosed with a spinal cord contusion with associated pre-existing cervical spondylosis and an acute disc herniation. On 7/11/18 he underwent an anterior cervical discectomy at C3-C4 with an interbody fusion with a PEEK cage and demineralized bone matrix. Despite the surgical procedure to decompress the spinal cord, Mr. Blasingame remained quadriplegic with only minimal sensory preservation. Mr. Blasingame was then involved in rehabilitation efforts and despite the lengthy period of time since his injury, he has not had any significant recovery of neurological function.

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I believe at this point it is highly unlikely he will experience any further improvement in his neurological condition.

Thomas Burns, Psy.D. has provided an analysis of the current diagnostic considerations and recommendations for treatment. I have been asked to render an opinion on the medical accuracy of those opinions. Dr. Burns has listed the following current diagnostic considerations:

DSM-V / ICD-10 Current Diagnostic Considerations:

Traumatic Brain and Spinal Cord Injury:

G93.89 Encephalomalacia

S06.6X9 Subarachnoid Hemorrhage with Edema

M48.02 Cervical Stenosis C3-C5 requiring fusion

Cognitive Sequelae:

G31.84 Mild Neurocognitive Disorder having a direct impact on the following:

- Word Finding Skill (dysnomia)
- Motor programming
- Organization & Problem Solving

F32.9 Major Depressive Disorder secondary to his injuries and lack of mobility

G89.2 R/O Chronic Pain involving shoulder injury

Dr. Burns has personally evaluated Mr. Blasingame and I have no reason to doubt the accuracy of these diagnoses based upon my review of the medical records. He further opines on the cause of his current deficits and likelihood of improvement. He states: "Mr. Blasingame's current neurocognitive deficits are consistent with a traumatic brain injury involving the frontal lobe of the brain and injury to the cervical region of the spine. This includes his low scores on measures of executive function, quadriplegia, as well as word finding difficulties. While the differential diagnostic considerations should include Mr. Blasingame's cocaine use and educational attainment, it is clear that his mobility issues were not present prior to the incident in 2018, leaving him with a guardian and unable to make decisions regarding his financial situation and/or medical decision making. Mr. Blasingame's motor limitations, pain, and cognition are more likely than not going to be present as he continues to age, and he will require a facility to address his physical, cognitive and emotional needs. As he ages, these domains will continue to be present in his life."

In general, I also agree with this assessment although it should be pointed out that it is impossible to determine precisely Mr. Blasingame's pre-existing neurocognitive ability since he did not have a baseline test performed prior to his incident. This is particularly true given his history of significant drug abuse which may have had a significant impact on his cognition. As noted in Dr. Burns' report, prior to the incident in 2018, Mr. Blasingame had a multi-year history of cocaine abuse. He recalls trying heroin via IV administration and drank some beer and liquor but recalls cocaine as being his drug of choice while living on the street.

The opinions provided are stated to a reasonable degree of medical certainty.

Respectfully,

A handwritten signature in cursive script, reading "Daniel Barrow".

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